Healthcare Group of Arizona

Employee/Dependent Enrollment/Change Form

www.hcgaz.com • 602.417.6755 • 800.247.2289 (outside Maricopa County)
701 E. Jefferson St. • MD 1400 • Phoenix, AZ 85034 • Fax: 602.417.6798

A State-Sponsored Health Plan

Business Name ______________________________

Group ID ______________ **Member ID H000#** ______________

Please make a selection from one of the following sections (enrollment change, waiver or COBRA):

Enrollment Change: ❑ Add Employee ❑ Address Change
❑ Marital Status Change ❑ Name Change
❑ Add Dependent ❑ Add Newborn ❑ Add Dependent by Adoption
❑ Add Dental/Vision (during open enrollment only)

Waiver *(Complete Section A Only)*: ❑ Coverage through Spouse ❑ Coverage through Parent
❑ Government Program ❑ Individual Coverage

❑ Other ______________________________

COBRA: ❑ Enrollment
Employee Coverage: ❑ Termination ❑ Reduction of Hours ❑ Retirement
Dependent Coverage: ❑ Divorce ❑ Death of Employee ❑ Child Lost Eligibility

HCG USE ONLY

Eff. Date ____________ Health Plan ____________

Option Code ____________ Late Enroll: ❑ Yes ❑ No

SP Event ______________________

W/P ____________ Renewal ____________

Rep. ______________________

Today's Date ______________________

DATE

SECTION A ATTENTION: Failure to provide all required documents and make necessary payment in full will result in a delay in processing employee/group request.

Employee Last Name ______________ Employee First Name ______________ MI ______

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Employee Home Address ______________________ City ______________

County ______________ State ______ Zip Code ______________ E-mail Address ______________

Household Size ______________ Annual Household Income (including yourself, spouse, and children) $______________

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Legally Separated ❑ Widowed

Occupation/Title ______________________ Hours/Week ______________ Date of Hire ______________

SECTION B Are you eligible and/or enrolled in Medicare? ❑ No ❑ Yes // If enrolled, which part? ❑ Part A ❑ Part B ❑ MA ❑ PD

Do you have other Medical Coverage? ❑ No ❑ Yes Carrier ______________________

Please select a Healthcare Group Managed Care Option:
❑ Mercy Healthcare Group (available in Gila, Graham, Greenlee, Maricopa, Pima, Pinal, Santa Cruz & Yuma Counties Only)
❑ University Healthcare Group (available in Cochise, Graham, Greenlee, Maricopa, Pima, Pinal & Santa Cruz Counties Only)

Benefit Level: ❑ Classic ❑ Secure Advantage ❑ Active ❑ Silver ❑ Copper // Deductible $______________

SECTION C List all family members who are being added/enrolled.

Last Name	First Name	MI	Date of Birth	Gender (m/f)	Relationship	Disabled Adult Dependent	Full-Time Student	Primary Care Physician (Managed Care only)	Existing Patient	Medical	Dental ❑ EDS[1] ❑ PPO	Vision
Employee									❑ Yes ❑ No	X	❑ Yes ❑ No	❑ Yes ❑ No
Spouse									❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Dependent [1]						❑ Yes ❑ No	❑ Yes ❑ No		❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Dependent [1]						❑ Yes ❑ No	❑ Yes ❑ No		❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Dependent [1]						❑ Yes ❑ No	❑ Yes ❑ No		❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Dependent [1]						❑ Yes ❑ No	❑ Yes ❑ No		❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Dependent [1]						❑ Yes ❑ No	❑ Yes ❑ No		❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

[1] If Subscriber is enrolling an Adult Dependent, please fill out the Adult Dependent Section (Section D) on the next page/on the back of this form.

[2] If You are Choosing the EDS Dental Plan, enter your family Dentist's name ______________________ Dentist code # ______________

continued on back/2nd page >>

ENR011–1011–MERCY/UPH-HMO–v5

Please complete for enrolling Adult Dependents ages 19 up to 26

Adult Dependent's Last Name _____ Adult Dependent's First Name _____ MI _____

Home Phone _____ Work Phone _____ Cell Phone _____

Home Address _____ City _____

County _____ State _____ Zip Code _____ E-mail Address _____

Adult Dependent's Employer _____ Employer's Phone _____

Please read and initial the following:

_____ I understand that Adult Dependent Coverage will end at age 26 without further notice.

_____ I verify that my Adult Dependent is not eligible for employer-sponsored coverage and that this enrollment is pursuant to the Patient Protection and Affordable Care Act.

INSTRUCTIONS:

HOW TO ADD A MEMBER (Employee or Dependent):
Instructions: Employees and their dependents are eligible to receive benefits, during the group's annual open enrollment renewal period, when they have met the Groups' required waiting period (if applicable) as a "Late Enrollee", or during Qualifying Events for Special Enrollment Periods.

Necessary Forms: ❑ Employee/Dependent Enrollment/Change Form ❑ Member Health History Form (for each Employee and Dependent)
❑ Employee Checklist (not needed for dependents) ❑ Proof of Employment

Timelines: All necessary enrollment forms, documents and two months' premium must be received before the 20th of the month prior to the effective date to ensure coverage will be in effect for the new employee or dependent on the first of the following month. Please allow up to 3 weeks from receipt date for processing, including member identification cards.

Premiums: Two months' premium for each added member must be included with the required paperwork.

Newborns (Birth, Adoption or Legal Placement): Newborns must be added within 30 days of the birth with required two months' premium payment. Birth certificate must be received by HCGA within 60 days or the newborn will not be covered retroactive to the date of birth. If adoption or legal placement, a copy of documents conveying legal status of newborn must be included.

Adult Dependents (up to 26 years old): A copy of the birth certificate or a paternity decree providing proof that the Subscriber is the natural or adoptive parent of the Adult Dependent is required.

PLEASE NOTE: Check(s) issued to Healthcare Group of Arizona for a premium payment does not bind coverage. The check(s) will be processed and placed in a credit account pending completion of group's enrollment. If eligible, the amount will be applied toward the premium payment.

COBRA COVERAGE (if currently on COBRA or applying for COBRA)

COBRA ELIGIBILITY:
- Applies to Employer groups with 20 or more employees
- Employees and their dependents are eligible for COBRA coverage if enrolled with a group of 20 or more employees
- Applicants have 60 days after their group coverage ends to convert to a COBRA policy
- The employer group must continue offering the HCG coverage for eligible employees to enroll in COBRA coverage

I UNDERSTAND THAT:
- My COBRA coverage is subject to state and federal laws; AND
- I am subject to the terms and conditions of the Employer Group Service Agreement; AND
- I am financially responsible for payment of this coverage and that my failure to pay will result in loss of coverage.

Employers are responsible for the Administration of the COBRA coverage including collection of the premiums.

CONTACT INFORMATION FOR HEALTH PLANS

Mercy Healthcare Group Member Services: 602.798.2800 or 800.780.2300
University Healthcare Group Member Services: 520.690.6811 (Pima County) 888.708.2930 (Outside of Pima County)

All information contained on this form is considered confidential and may be used strictly for program management and statistical reporting purposes by Healthcare Group of Arizona.

Please Note: By signing below, I acknowledge that the information provided on all pages of this application is complete and true to the best of my knowledge. I acknowledge that the discovery of facts known to me and not disclosed may result in prosecution and that Healthcare Group coverage for myself and my dependents may be rescinded. I also acknowledge that I will be financially responsible for all costs incurred if I have failed to disclose all required information.

Employee Signature _____ **Date** _____

Employer Signature _____ **Date** _____